Draft Report of Beaumont Hospital Diagnostic

July 2012

Strictly Confidential

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Executive Summary

A team from the Special Delivery Unit and Clinical Programmes was requested by Dr James Reilly, Minister for Health to carry out a diagnostic exercise in Beaumont Hospital on the 12th and 13th of June 2012.

Beaumont Hospital is the largest public hospital in the north Dublin region, with 815 beds including St Josephs Hospital Raheny, and serves a local population of just over 290,000 people. Beaumont is the National centre for Neurosurgery, renal transplantation and cochlear implants. It is also a designated cancer centre as per the National Cancer Control Programme and provides a variety of regional services.

Beaumont Hospital had consistently demonstrated the highest number of patients waiting on trolleys in the Country with a deteriorating 30 day average trend. The diagnostic team were specifically interested in the Patient Pathways in the Emergency Department, Medicine, Surgery, and Frail older Persons. Overall capacity management, Data Management, Discharge Planning, Diagnostics and Ambulance Service were also examined.

The team that carried out the diagnostic were

Ms Lis Nixon, Director of Performance Improvement, Unscheduled Care.

Professor Frank Keane, Clinical Lead, Surgical programme.

Dr Simon Walford, Clinical Advisor to the programmes.

Mr John McLoughlin, Performance Improvement Specialist.

Dr Declan Bedford, Public Health Specialist.

Ms Anne Keating, National Strategic Lead in Bed Management and Discharge Planning.

Healthcare delivery is currently going through a period of tremendous change. There is considerable concern about uncertainty in the system. The key to managing a system through such a period where the imperative is to deliver high quality cost effective care whilst managing to new targets and measures is strong leadership, corporate and clinical organisational values and good communication throughout the organisation where every stakeholder knows what is expected of them and what they are responsible and accountable for.

The team wish to thank all staff who gave of their time and participated freely on the day. As an overall comment it is clear that there are many positive change initiatives happening in Beaumont to improve the patient pathway and patient experience.

There was some frustration expressed by staff during the visit that improvements were not yet impacting on the trolley numbers in Beaumont and a general comment about uncertainty and trying to stay focused with the pace of change was made by several of the participants.

The key issues can be grouped into the following headings:

- Corporate and Clinical Leadership and making the Strategic Vision /Plan work.
- Moving towards processes which follow guidelines and pathways to improve and ensure a consistent patient experience across all specialities

- Changing the delivery of care model by better organisation and streaming of patients with clear mapping of the Who / What /When /Where and How in the delivery of Care.
- Re-organising and re-designating physical and process infrastructure to meet demand in a timely manner.
- Physician and Clinical Relationships
- Resource Issues and the challenge of maintaining quality and access in the current economic climate.

Emergency Department – Tour of Facilities

Patient journey

Walk-in patients arrive at reception which is shared with Ambulance patients. All of the urgent ambulance patients and any other patients with major injury, chest pain, or stroke are taken immediately to the Resuscitation area;

If the patient is not a Category 1 or unstable Category 2, they are triaged in the Emergency Department (ED) and then go to a trolley or chair in the main department. The ED clinical staff we spoke to report few delays in turnaround time in ED. This view was not shared by ambulance staff whom the team met later.

At the reception desk there are from 1 to 3 receptionists. The waiting area is shared during the day with fracture clinic and so the ED receptionists are also dealing with these patients. After reception, patients are triaged - should be within 15 minutes but often takes longer, up to 40 minutes. 95% of the time there are three nurses in triage with a rapid access triage nurse from 8am to 9pm. Patients in triage categories 3, 4 or 5 are further classified according to urgency (Manchester grading) as Green, Yellow or Orange. Category Green patients, especially those with minor injuries are managed by an Advanced Nurse Practitioner (ANP) when on duty.

Category Yellow patients wait to be seen by a Doctor. This can be for as long as 14 hours although they may have had some diagnostic tests during this wait. Doctors, at assessment, may further investigate, arrange x-rays and then decide upon discharge or admission - 36% of this patient category is admitted. The four ANP's have completed the nurse prescriber and the x-ray prescribing course. The CNS in wound care is able to prescribe analgesia as is one of the rapid access triage nurses. Two protocols have been written to administer Intravenous (IV) and oral (PO) paracetamol and PO ibuprofen to patients. The hospital hopes to commence the teaching process by the end of the month so that all nursing staff will be able to prescribe these analgesics.

Following the decision being taken to admit the patient they then wait on a trolley or a chair in the ED for a hospital bed (which can be up to 2 days), sometimes in the corridor or annexe, without privacy, often packed close together and without room to be adequately assessed. Furthermore, the exact whereabouts of these patients is only known and monitored by one nurse and can constantly change which means that no one clearly knows where individual patients are. (Comment: we feel that this constitutes a significant risk to patients and has to be addressed as a matter of urgency). - Addendum: This has already been addressed by the Hospital with the addition of numbered areas for all patient trolleys and chairs and the cessation of the use of the annexe.

Category Orange patients are often seen by the Rapid Assessment Nurse, again the aim would be to see these patients within 30 minutes but this is currently often a number of hours. The nurses and doctors work well as a team with this group of patients and could perhaps extend to seeing some of the higher acuity patients.

Medical patients may be seen in the AMU (4 or 6 trolleys) for medical assessment and management and/or admission. (see AMU flow notes later)

Currently GP referred patients go through ED and cannot go straight to AMU without undergoing the triage process described above. This is currently leading to significant delays and is viewed as an unnecessary step in their pathway as they have already been assessed by their GP. The AMP strongly recommends that GP referrals go direct to the AMU. Currently the AMU closes at 8:30pm but does not admit patients beyond 4pm. (see AMU notes re. extended opening hours).

At 8am on the morning of this visit there were 60 patients in the ED, 40 awaiting admission and 20 waiting to be seen by an ED doctor or speciality team, with a further 10 requiring to be triaged. There was no clear system of monitoring the waiting times for patients – they were all registered and entered on the ED IT system but were not in time order and were placed on the system according to the area they were waiting in rather than their chronological arrival time. Consequently, there was no easy way to determine who had been waiting for more than 6 hours, where they were waiting or what point in their pathway they had reached.

A regular escalation area for patients awaiting a bed is the 22 bedded Day Ward which regularly houses up to 14 ED admissions of all diagnostic categories. Clearly this has a detrimental impact on the ability of the surgical teams to provide day surgery services to their group of patients and will only ever be a transitional space for the emergency patients.

Staffing of ED

There are three consultants who are rostered to work 8am – 6pm, Monday to Friday each having a day off per week. They provide on call cover on a 1 in 5 rota (with some senior Staff Grade doctors) at the weekends. The on call consultant usually attends the ED on both Saturday and Sunday mornings. A fourth consultant post has been approved.

Non Consultant Hospital Doctors (NCHD's) – There are 2 Associate Specialist Registrars, 6 registrars, 11 Senior House Officers (SHO's) and 1 intern. Our understanding is that there are 3 Registrars and 4 SHO's in core hours and Out of Hours 2 Registrars and 3 SHO's all with different start and finish times.

Nursing - The Emergency Department has an allocated nursing compliment of

- I WTE Clinical Nurse Manager (CNM) 3
- 9.1 WTE CNM 2 (including G.P. Liasion)
- 4 WTE Advanced Nurse Practitioners(ANP's) (Minor Injury)
- 1 WTE Clinical Nurse Specialist (CNS) (Wound Care)
- 37.14 WTE Staff Nurses
- 4 WTE HealthCare Assistants
- 1 WTE Education Co-ordinator

This Nursing Compliment supports Emergency Department core functions such as Triage, Resuscitation, Minor Injury, Assessment and the Care of Admitted patients within the Department. With the ongoing high number of admitted patients within the Department, it currently functions with 2 ANPs, I CNS Wound Care (Mon to Fri), 1 CNM3 (Mon to Fri) 1 CNM2 co-ordinator (Day & Night) and 10 staff nurses on day and 9 staff nurses on Night duty. There is one HealthCare Assistant on duty both on day and night duty to support Nursing staff to carry out their roles.

Vacancies currently: 5 CNM2 posts, 4 WTE staff nurses from current compliment.

One of the initiatives explored and progressed since November 2011 has been the Rapid Assessment Nurse. From Jan to May these two CNMs have seen 1738 patients managing 380 under protocol to discharge. They provide only a Monday to Saturday service at present. An additional WTE in this field would allow for seven day coverage. It would be envisioned that the role will have ongoing development to increase scope of practice for this service to see and manage more category yellow patients.

The hospital does roster a higher complement of senior staff on the busiest days: Monday, Tuesday and Friday.

Recommendations :

Note - It has to be recognised that ED attendances are continuously increasing (+5.9% ytd) and will do for the foreseeable future. Any solution(s) must anticipate this increasing demand.

- *A detailed profile is required with clear demand mapping by number of presentations by hour of day /day of week for all categories planned against the physical infrastructure which will then inform workforce planning.*
- *There needs to be a greater institutional wide acknowledgement that the present ED crisis is a hospital wide problem and not simply a problem at ED level. This will require hospital staff and Clinical Directorates each taking greater responsibility for streaming their own patients from a much earlier point in their journey.*
- *As AMP processes have started to improve, surgery now accounts for a greater proportion of long waiters in ED. Surgery needs to start processes to address this. (See under Surgery)*
- *Solutions will be multifactorial given that additional resources at this time are not an option. They can be divided into a) Those that speed up the processes, and b) Those that allow patients to be admitted, discharged or referred on immediately.*

Areas to be addressed:

1. *More active processing and ownership of patients by the presence of ED senior medical staff covering more flexible 'long day' (8 to 8) rosters. The 4th ED consultant should be appointed without delay.*

2. *More flexible approach to GP referrals direct to Hospital Clinical Teams, AMU or ASU (See under Surgery)*

3. *Greater use of (and more) ANPs to cover 24/7, 7 days /week and extend the ANP role to enable ordering of X-rays, prescribing pain medication etc.*

4. *A review and enhancement of the role of the CNM2 co-ordinator role to the unit to manage the patient flow and co-ordinate the MDT that works within the Department is recommended as being essential to the aim of meeting a six hour target within the Department.*

5. *Clear performance monitoring and management which focuses on the patient pathway through ED and beyond, ensuring timely clinical intervention at every stage*

6. *Clear data management to ensure that the numbers of patients waiting are all in the Department and that the IT systems reflect real time data at all times.*

7. *Greater engagement by Clinical Directorates in the streaming and time lines of their own patients, including an improved metric of journey times as has begun in Medicine and should be taken up by all disciplines.*

8. *Either end of day (or twice daily) ED rounds by Senior Decision makers should be performed by relevant Clinical Directorates and ED Consultants. Ideally the Bed Manager and a member of the Senior Executive team should also attend these.*

9. *The creation of greater patient bed capacity for ED admissions has to be prioritised and provided by continuing inpatient process improvements and better management of long stay patients.*

10. *The AMU needs to work more effectively with more referrals in from ED and more "pulling" of patients from ED.*

11. *The present patient tracking and information system in ED is difficult to understand and not friendly for the wider staff. An interim solution of colour coding by waiting time needs to be introduced to enable clear management of the patients in chronological order realising that there will always be clinically urgent patients who may need to take priority. Clear alignment with the Visual Hospital project needs to be explored.*

12. *Pathways to all dependencies need systematic analysis for delays and inefficiencies including referral to clinical disciplines, timely access to diagnostic tests including laboratory tests, radiology, scopes and cardiac tests and availability of therapy services including OT and social work.*

13. *Open a CDU with clear protocols for the 6-8 patients who are currently on trolleys each morning in the ED and who could be more safely and appropriately accommodated in a CDU*

14. *We recommend an examination of the current GP practice to refer low risk chest pain to ED (in the absence of choice) and review the potential gain by moving the ANP cardiology and cardiac technician resource to a designated chest pain assessment area. Note this does not preclude patients with chest pains presenting to ED/AMU and we acknowledge it will remain one of the principal medical presentations to ED /AMU and a % being addressed in a CDU when present.*

15. *Develop a zero tolerance approach to specialty patients awaiting "potential discharge later post a diagnostic" or "further senior review later" remaining in ED.*

16. *To reduce congestion in the ED we recommend streaming at point of entry to ED.*

17. *We recommend more referral and use of the expert role in nursing in house by involvement of the specialty ANP and CNS role in the ED.*